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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Surgical Diagnosis.

By CHRISTOPHER HEATH, F.R.C.S., Holme Professor of Clinical Surgery in University College Hospital.

GENTLEMEN: Many surgical injuries and affections are so obvious that no great skill is required for their recognition; but, on the other hand, similar outward appearances may depend upon very different causes; and it is here that the skill in diagnosis of the surgeon gives him the advantage in prescribing appropriate treatment. Symptoms may be conveniently divided into "objective" and "subjective"; the former being those open to the observation of the surgeon, the latter those experienced only by the patient. It is to the objective symptoms of disease and injury that I propose to direct your attention to-day; for I do not mean, on this occasion, to bring a patient before you, but simply a living model with no special ailment, to illustrate some points in diagnosis.

It must be your great object to cultivate your eye, hand, and ear; and you cannot safely omit the use of any one of the three. Practically, one uses, as a rule, the ear first; because you are bound to hear something of the patient's own account of his ailment, in order to know to what part of his frame you are to direct your attention; though you must not put too much

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trust in a patient's own account, and still less in his diagnosis of his own malady. Thus, pain referred to the knee frequently depends upon disease of the hip, and pain in the loins from supposed kidney-disease, upon stricture of the urethra. The eye will take in many of the leading features of a case at a glance, such as the general aspect of the patient, his mode of walking or standing, etc.; and, when the affected part is exposed to view, it will in many cases, if sufficiently practised, complete the diagnosis. Let me warn you, however, against "jumping to conclusions" too rapidly; for those who are foolish enough to pride themselves on rapidity in diagnosis not unfrequently make mistakes which a little more time would have enabled them to correct. You can no more afford to leave out steps when tracing the nature of a case by progressive induction, than you can venture to omit one or more tests when examining a complicated fluid in the chemical laboratory. Lastly comes the hand, which may require to be fitted with various instruments for special purposes; but which, in its simplicity, is the surgeon's most powerful ally if properly educated. The much-talked-of *tactus eruditus* is to be acquired by all who will take the trouble to practise their fingers in the manipulation of healthy and diseased subjects, and will at the same time use their mental powers. For, of course, no amount of examination of a patient will tell you what is the matter with him, unless you elaborate the facts thus ascertained in a mind which has been trained by previous study to comprehend the importance of the several symptoms; and this is the reason why, at first, beginners must be at a disadvantage, lacking the experience necessary for a clear appreciation of symptoms. You will find, however, that with a little help from the surgeon, you will soon begin to see the "why" and the "wherefore" of diagnosis and treatment; and let me beg of you not to be afraid of asking questions—so long, at least, as the questions are put for the purpose of increasing, and not of displaying, your own amount of information. One pitfall I must just allude to; and that is the tendency to over-elaboration of a diagnosis which besets some men, and seems to stick to them through life. They never can take the plain obvious facts of a case, and from them draw a conclusion; but must dig and delve so deeply that they sometimes get, so to speak, "out of their own depth," and never come up again so far as any utility to the patient in question is concerned. Superficial carelessness is bad; but too great profundity is not much better.

And now I bring before you a man with no special deformity or ailment, in order that I may be able to show you a few noteworthy points which you can readily appreciate at a little distance, and which will assist you in studying disease and injury in the wards. With his back towards us, you have the opportunity of examining a healthy spine; and you may notice that, while the spinous processes are readily visible in the dorsal region (and particularly when the arms are folded), they are not so visible in the lumbar, and still less so in the cervical, region, where they are covered by muscles and ligaments, the seventh, or *vertebra prominens*, being the only one really seen or felt. Here, in a healthy adult, we have the average anterior and posterior curves in the lumbar and dorsal regions; but you must remember that, in young children, the spine is nearly straight, while in disease we may have great exaggeration of either curve. Thus, in the back, we find *cyphosis*, or angular curvature, the result of caries of the vertebræ; while in the loins we have *lordosis*, an exaggeration of the healthy curve, and generally connected with old hip-disease. Of the latter, I now place an example before you; and, of the former, there is an instance in No. 1 Ward, in a man whose foot I removed last week.

The model is now standing at "attention," with his knees straight; consequently the two sides of his pelvis are perfectly even; and you see that a tape carried between corresponding points on the two sides is horizontal. Let us now make him "stand at ease," with the left knee bent and foot slightly advanced, and you see that at once the left side of the pelvis is lowered. But this is not all.

Corresponding with the obliquity of the pelvis, we have a lateral deviation of the spine to the left in the lumbar region; and if the man could sufficiently relax his muscles at the moment, we should have a curve in the opposite direction—to the right—in the dorsal region. By placing a book beneath the right heel, and thus increasing the obliquity of the pelvis, I exaggerate the lumbar curve; or, of course, by tilting the pelvis in the opposite direction, I could throw the spine over to the opposite side. Of course, the same thing holds good if the patient be seated instead of standing; for, by tilting his seat, we are able to produce a marked lumbar and a certain amount of dorsal curve at will. Fortunately, we have here to-day also a case of old hip-disease, in whom the obliquity of the pelvis is well marked, and the resulting twist of the spine better seen than in the healthy subject. You see, then, how important it is in any case of lateral curvature to ascertain whether it depends upon some obliquity of the pelvis (from atrophy of one leg or old hip-disease), or upon other causes; and you also see what effect upon an existing curve may be produced, as has been well pointed out by Mr. Barwell, by raising the side of the pelvis by means of a thickened sole or a sloping seat.

Turning, now, to the neck and shoulder, I pass my finger along the clavicle, which is subcutaneous, and shows its curves well enough in a thin muscular subject. The notch between the clavicles is important in connection with aneurisms of the great vessels of the neck; but the inner end of the bone is very rarely dislocated, except by extreme violence. The outer end of the clavicle is continuous with the acromion process, and I now run the chalk along them; but it may be dislocated (as we have lately seen), and then the flattened end of the bone is readily felt beneath the skin. If I make the man swing his arm round, you will be able to appreciate better than you perhaps have hitherto done the great range of motion in the sterno-clavicular articulation, which, in fact, admits of "circumduction," and has a most important relation to the movements of the arm.

There is no joint, I suppose, about which more mistakes are made than about the shoulder. An "obscure injury about the shoulder" has often damaged a surgeon's reputation, because he has not sufficiently studied the anatomy of the part to be quite sure of his diagnosis and treatment. The chalk-line I have already made marks the bony arch formed by the clavicle and acromion; but you will notice that the head of the humerus projects beyond this in front, and gives the roundness to the healthy shoulder. There is a hollow immediately behind the head of the humerus and below the prominent acromion; and another in front, to the inner side of the head, in which the coracoid process can be more or less distinctly felt, according to the muscularity of the subject. In the healthy subject, there is just room to lay the finger between the coracoid process and the head of the bone. When the head of the humerus is *dislocated*, the roundness of the shoulder is lost, and the acromion stands out prominently beneath the skin, with a depression below it; while the head can be felt in some unnatural position, and out of its proper relation to the coracoid process. The direction of the whole limb is altered too; so that the patient cannot place his hand on the opposite shoulder with the elbow touching the chest-wall, as he can in health. In a *fracture* of the neck of the humerus, the roundness of the shoulder is not lost; but there is a depression below the head, which does not move when the arm is rotated, unless, indeed, the fracture be impacted. The two accidents may be combined; but this is a rare complication.

When I turn the model with his back to you, and make him raise his arm, you will appreciate how important the movements of the scapula are. The deltoid alone can only raise the arm to a right angle with the trunk; and the subsequent elevation of the limb depends upon a rotation of the scapula on the ribs, so that the angle comes forward to the margin of the axilla. The scapula is held in its place by the muscles passing from the spine to its base, and by the serratus magnus. If these be paralyzed, the scapula falls for-

ward, and the power of the arm is greatly lost.

Let us pass on to the elbow. With the forearm bent, you see at once the prominent olecranon process of the ulna. When this is broken off by falls on the elbow, the fragment is drawn up by the triceps, and an interval can be felt between it and the bone, which, however, is rapidly filled up by the effusion immediately following any injury to the elbow-joint. A much more common result of a fall on the elbow, however, is an injury to the bursa which lies between the subcutaneous triangle of the olecranon and the skin. In health, this bursa cannot be recognized, except in individuals whose occupation has produced enlargement of it—*e. g.*, miners or sweeps; for though it is technically called the "student's bursa," I must confess to have never seen an enlargement of it due to long poring over medical treatises. When the bursa is inflamed, it causes a swelling over the olecranon, which is evidently quite superficial, and does not mask the general outline of the joint, as would be the case were the effusion in the articulation. You may remember that, last week, a patient with suppuration of this bursa was treated by an early and free incision in Ward 1.

The condyles of the humerus are readily felt in this thin arm; and you will notice that the internal is the more prominent, and stands out beneath the skin. Immediately behind it is the groove in which the ulnar nerve lies, as you may ascertain for yourselves by "twanging" it; and then comes the olecranon, with only just space for the nerve between the bones. This close relation of these two prominent points of bone is of great service in the diagnosis of dislocation of the forearm; for, so long as they lie close together, the deformity cannot be caused by a dislocation of the ulna. The outer condyle is more rounded; and immediately below it is the head of the radius, which can be felt rotating when the forearm is pronated or supinated. It is not often dislocated, for it is firmly held by ligaments; but it is sometimes thrown forward, and then prevents complete flexion of the forearm, by coming against the front of the lower end of the humerus.

At the wrist, you may notice that the end of the radius is lower down than that of the ulna, and that the styloid processes of both bones are to be felt. Dislocation of the carpus from the radius is rare; but separation of the lower epiphysis of the radius is by no means uncommon in young persons, and is sometimes mistaken for dislocation. The triangular fibro-cartilage which binds the radius and ulna together at the wrist, sometimes becomes displaced in children who are dragged forcibly by the hand, and then the little patient cannot supinate the forearm and hand; but if you hold the hand firmly, and then supinate, you hear a slight click, and all is well. It is well always to bear in mind that, in supination, the bones of the forearm are parallel, and in pronation are across one another; so that supination is the posture in which fractured bones of the forearm should be set, although it is convenient, when the bones are firmly held by splints, to turn the thumb upwards—*i. e.*, to place the hand midway between pronation and supination.

In the hand, I need only point out that the superficial palmar arch does not correspond precisely to any one of the lines in the skin of the palm; but its convexity reaches generally to the middle one of the three, while the deep arch is much nearer the wrist. The bifurcation of the digital arteries is between the heads of the metacarpal bones, and about midway between the line to which I have referred and the web of the fingers; so that incisions should always be made in the line of the fingers, and not between them. As you may have, early in your career, to amputate a crushed finger, I would remind you, also, that the prominence of each knuckle is formed by the proximal bone of the articulation; and that the joint through which the knife must pass is below this in every case.

Descending to the groin, you see that the fold of the groin corresponds to Poupart's ligament; and an inguinal hernia is above, while a femoral hernia is below, this line—at least at first. Of course, a large inguinal hernia will descend into the scrotum, and a large femoral hernia may turn up over Poupart's ligament, and

closely simulate the inguinal variety. But you ought to have little difficulty in distinguishing them if you will invaginate a piece of scrotum (or labium in the female) on the forefinger, as you see me doing, so as to carry the finger into the external abdominal ring. This will enable you to settle at once whether the protrusion has taken place through the inguinal canal or not. Let me also remind you always to ascertain the presence of two testicles in the scrotum; for an undescended testis may closely resemble a hernia, especially if inflamed.

The pelvis is so firmly bound together that a dislocation of one of the innominate bones can only be produced by extreme violence; but disease of the sacro-iliac joint is by no means uncommon, though often overlooked; and one leading symptom is lameness, which is erroneously referred to the hip-joint. But if I make the man before us stand on one leg, you will see at once how the whole weight of the body falls upon the corresponding sacro-iliac joint while he is throwing the other leg forward; and it is this which gives rise to the pain, and prevents the walking of a sufferer from sacro-iliac disease. Taking this man, who has a healthy pelvis, I may compress his two innominate bones without giving any pain; but a woman who has recently had a severe labour, and has, perhaps, incipient sacro-iliac mischief, will cry out at any such rough treatment, though the steady support of a good pelvic belt would give her great comfort, and restore her powers of locomotion.

The hip-joint in health is freely moveable in all directions, as you see, and independently of the pelvis; but, the moment the joint is inflamed, the muscles instinctively contract, and fix the joint to some extent; and then, when the limb is moved, it carries the pelvis with it. This man's back is naturally more curved than a child's; but even in him, if I make him lie flat on the table, you will see that the thigh can be fully extended without tilting upon the pelvis, and so increasing the curve of the lumbar spine. In a child, whose back is naturally flat on the table, the effect of early hip-disease is readily seen (as I have frequently demonstrated to many of you); for the attempt to bring the thigh down, at once elevates the pelvis, and causes that curvature of the lumbar spine which, in old hip-disease, becomes permanent.

The prominence of the great trochanter will vary in different individuals, according to the muscularity of the buttock and the length of the neck of the femur; and it is important, therefore, to compare the two sides in every case of suspected disease or injury. The head of the femur can be indistinctly felt on deep pressure, either in front of or behind the trochanter; and, in health, the two move together; for if the trochanter can be freely moved by rotating the femur without affecting the head of the bone, it is clear that the neck must be broken. The length of the neck will very much affect the power of rotating the limb; thus, if the neck be shortened, either by an impacted fracture or the absorption of old age, the arc in which the upper part of the thigh moves will be found to be much smaller than in health. When I stretch a tape from the anterior superior spine of the ilium to the tuberosity of the ischium, you see that, in health, it touches the top of the greater trochanter; now, if the bone were dislocated or the neck broken, the trochanter would be above or below this line.

When the knee is extended, you see the patella forming a prominence in front of the femur; but, when the joint is flexed, it sinks into the hollow between the condyles. With the leg fully extended and the muscles relaxed, there is, as you can prove in your own limbs, considerable lateral movement of the patella possible in the healthy joint; and the mistake is sometimes made of attributing this mobility to the presence of synovial effusion. When fluid is poured into the knee-joint, however, not only does the patella float so as to be freely movable in any position of the limb, but the synovial pouches on each side of and above the patella are distended, and give the characteristic roundness to the knee. If one kneel down on a flat surface, and particularly if the body be bent forward, as in scrubbing a floor, the patella and the bursa between it and

the skin are exposed to considerable pressure; and hence the chronic enlargement of the bursa, termed "housemaid's knee," which causes a globular swelling in front of the joint, altogether different from that of effusion. Kneelers on hassocks or foot-boards do not run any risk of the housemaid's fate; for the pressure in their case comes on the tubercle of the tibia, and the bursa between it and the *ligamentum patellæ* would suffer if the pressure were sufficiently prolonged—but I never met with such a case. In falling with the knee bent, the patella reaches the ground first, and receives the force of the impact, which may simply bruise or cut open the bursa; or, if very severe, may "star" the patella itself. The transverse fracture of the bone is produced through the effort of the patient to save himself, by which the great extensor muscles catch the bone across the condyles, and either break it or rupture the ligament; then the upper fragment is drawn up in front of the femur, and a space is left in which the condyles can be felt, as in a patient recently in the wards.

With the knee flexed, the rounded outlines of the condyles can be readily felt resting on the top of the tibia; and a little distance below the outer condyle can be seen the head of the fibula—which bone, let me remind you, does not enter into the formation of the knee-joint. The existence of the semilunar fibro-cartilages between the femur and tibia is hardly appreciable in health; but their existence must not be forgotten, as occasionally, in violent wrenches of the knee, one of them becomes displaced, giving rise to extreme pain and inability to use the joint, which are most satisfactorily treated (as also are dislocations of the patella) by a little of that judicious violence for which "bone-setters" have a reputation.

At the ankle, we see at once the prominences of the two malleoli, between which the astragalus fits closely when the foot is at right angles to the leg, less so when the foot is pointed; so that, in this position, some amount of lateral movement of the foot is possible. The fibula is altogether posterior to the tibia, and its malleolus is longer than the internal. The lower third of the fibula is subcutaneous, and its fracture (Pott's fracture) is therefore readily recognized. The tendons of the various muscles surround the ankle-joint; but the only one to which I need call your attention is the *tendo Achillis* at the back, in which, when ruptured, the division is readily both felt and seen. When I flex the knee and point the toes, you can see how completely the muscles of the calf are relaxed; and this is an important point in the treatment of a divided tendon, or of a dislocation of the foot, or oblique fracture of the tibia.

The prominences of the foot are chiefly important as guides to the amputations; thus the tuberosity of the scaphoid on the inner side marks the transverse tarsal joint, or site of Chopart's amputation; whilst the base of the first metatarsal on the inner or prominent fifth metatarsal bone on the outer side, marks the position of Hey's amputation. The metatarso-phalangeal joint of the great toe is not unfrequently diseased through gout or the pressure of boots which have developed a bunion; and other toes are not unfrequently deformed from the same cause. The only surgical point with regard to the toes that I need mention is that the base of the first phalanx is more expanded and more deeply placed than young operators are apt to imagine.

I have thus run briefly through the more salient points on the living body which it is important for you to recognize thoroughly in health before attempting to treat disease; and, in future lectures, I shall have to direct your attention to matters regarding which the knowledge acquired to-day will be of service in enabling you to recognize deviations from the standard of health.—*British Med. Journal*, Oct. 23, 1875.

HOSPITAL NOTES AND GLEANINGS.

Cases of Syphilitic Headache and Neuralgia cured by Calomel in small and repeated doses.—In syphilitic headache, which is always so painful and often produces obstinate insomnia, as well as in neuralgia of venereal origin, Trousseau used to prescribe calomel in very small and repeated

doses; for instance, one centigramme (or about one-sixth of a grain) a day, divided into ten doses, administered at one hour's interval, so that the patient would take one milligramme only (or about one-sixtieth of a grain) every hour.

Dr. PETER, of Hôpital St. Antoine, following Trousseau's example, uses this drug in similar cases as well as in doubtful ones, in which it has the excellent effect of speedily determining the nature of the disease.

Dr. Peter often quotes the instance of a young girl who entered Trousseau's wards for a severe facial neuralgia. For more than fifteen nights the patient had not slept, on account of the intensity of the nocturnal pains. The illustrious "clinician" noticed on the girl's temple the presence of a very small tumour, painful on pressure, and which he thought must be of syphilitic origin. Possibly the tumour rested on some filament of the temporo-facial nerve and produced irritation of it. Anyhow, he resolved to prescribe calomel immediately in doses as above described. The very same night the young woman slept four hours. The next night was attended by perfect sleep, and the pain disappeared entirely on the third day, though the size of the tumour had not much decreased.

Amongst other cases treated in like manner by Dr. Peter, the following are worthy of being noted.

A woman, aged twenty-three, was admitted on October 9th, 1874, for various syphilitic manifestations, large *plats muqueux* of the vulva and anus, a general papulo-squamous syphilitic eruption, etc. For these lesions the patient had already been put under a course of protoiodide of mercury before entering the hospital. But her chief complaint was a most violent nocturnal headache, beginning at 4 P. M. and lasting till 4 A. M., and which completely deprived her of sleep. Moreover, she had fever, and complained of intense pain along the nerves of the left arm and in the brachial plexus of the same side. On October 10th, instead of continuing the use of the protoiodide of mercury, as had been prescribed in town, Dr. Peter ordered one centigramme of calomel in ten doses, each to be given at an hour's interval. The next day (the 11th) the patient's report was that she had suffered less during the night. The headache commenced only at 6 P. M., and left her at 2 A. M., after which time she was able to sleep. The pain in the arm had been the same. In the night of Oct. 11th–12th the headache almost completely disappeared. It commenced very slightly at 7 P. M., and was so slight that the patient was able to sleep almost the whole night. The fever had also ceased. The calomel was then discontinued, nevertheless the night of October 12th–13th was excellent. The headache went off entirely, and the pain in the arm had diminished considerably. From that moment the classic treatment of syphilis, viz., the protoiodide of mercury, was resumed in order to combat the other syphilitic manifestations.

In another woman, who entered Dr. Peter's wards on the 29th of February this year, the syphilitic headache had been going on for nearly a month. It had been general at first, but after a fortnight became confined to the left side of the head. As usual, the pain was much more intense at night than in the day, and prevented sleep. Together with this headache, the patient complained of an intense pain in the right side, and indeed it was for this latter ailment that the patient had sought admittance into the hospital. Dr. Peter stated that it was seated in the situation of the chondro-costal articulation of the left side, which was slightly tumefied. Moreover, the patient had syphilitic roseola. On Feb. 22d ten milligrammes of calomel were prescribed, but through some mistake only two were given. The patient suffered much from the head during the night. On the 23d ten doses were administered. The headache disappeared almost completely, and the patient slept for ten hours. On the 24th, the stitch in the side, which had been already less painful two days before, when only two doses were taken, diminished to such an extent that it required rather strong pressure to produce any pain. On the 25th the ten doses were again forgotten, and the patient did not sleep so well as on

the previous night. The sleep was, however, better than at first, and the headache less intense than before the calomel was used. The ten doses were given this day, and the patient slept from 8 P. M. till midnight. From that hour she only got sleep in snatches, but without having any pain in the head; the pain in the side had by this time completely disappeared. On the 27th the general treatment of syphilis with a syrup containing iodide of mercury and iodide of potassium was commenced. The headache was only felt two hours in the nights of the 27th and 28th, and afterwards entirely ceased.

The remarkable features of this mode of treatment, says Dr. Peter, are—first, the rapidity of its action; next, the fact that it is successful in cases where the really specific treatment of syphilis fails. It constitutes, in a manner, *the* medicine of nocturnal syphilitic pain; but cannot replace the other plan of treatment for other syphilitic manifestations. Its use is indicated whenever nocturnal pain is very intense and interferes with sleep. It diminishes pain and its consequences the very first night it is given, and generally extinguishes suffering by the second night. The treatment may be carried on for three days, and that period of time is almost always enough for its success. If, however, the desired result has not been obtained, it ought then to be suspended for one or two days, so as to prevent salivation; and it can be resumed afterwards for two days successively, in which case Dr. Peter has never seen it fail.

Dr. Peter thinks that this plan of treatment is thus efficacious because, first, the drug is mercury; and secondly, the absorption of these very small doses is exceedingly rapid, and the repetition of the action takes place every hour. Whatever the explanation may be, adds Dr. Peter, it is to Trousseau that he is indebted for the idea of using calomel in this manner, and to him belongs all the credit.—*Lancet*, Nov. 6, 1875.

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Treatment of Lead Colic in the Paris Hospitals.—"In going through the wards of La Charité Hospital lately, I was struck," writes the correspondent of the *Medical Times and Gazette* (Dec. 4, 1875) "with the number of patients I saw there suffering from lead or painter's colic, for in one ward alone there were no less than six cases to be seen. I at first could not account for the presence of so large a number in this hospital, but, remembering that it had the reputation of more successful cures of lead-poisoning than any other hospital, I made inquiries as to the particular mode of treatment adopted, and was furnished with the following formulæ, which I reproduce for the benefit of your readers, as I have no doubt it will interest them to know what is meant by 'traitement de La Charité,' when applied to cases of lead colic. On the first day a purgative enema composed of infusion of senna, sulphate of soda, and powder of jalap is administered. This is followed by a purgative mixture called 'eau de casse' (cassia), and is composed as follows: Decoction of tamarind sixty grammes, water 1000 grammes, tartar emetic fifteen centigrammes—which the patient is to swallow in the course of the day; besides which he is to have a jug of decoction of guaiacum. In the evening an enema of walnut oil 125 grammes, ordinary claret 300 grammes. This is followed by a 'bol calmant,' composed of theriaca four grammes, opium five centigrammes. On the second day the patient is supplied with a drink composed of tartar emetic twenty-five centigrammes, water 500 grammes; this is facetiously designated 'l'eau bénite' (holy water). Besides this, he is treated with the same 'tisane' (decoction of guaiacum), the same enema, and the same bolus as on the first day. On the third day the patient drinks in the early morning two tumblers of a tisane composed of equal parts of an infusion of senna and decoction of guaiacum, and in the course of the twenty-four hours he is to take the same tisane, enema, and bolus as on the preceding days. On the fourth day a purgative draught of senna and jalap, followed by the tisane of guaiacum during the day, and the bolus at bedtime. Fifth day: Two tumblers of laxative tisane ordered on the third day, followed by the tisane of guaiacum, enema, and bolus as before. Sixth day: Idem.

Seventh day: The two tisanes, the same enema and bolus as previously. For the first three days the patient is condemned to '*diète absolue*,' which means total abstinence from food of any kind! This treatment, it must be confessed, must either kill or cure the patient, and strange to say, though purely empirical, it is considered the classical treatment for lead colic in the Paris hospitals, and is said to have been instituted by the monks that were attached to the Charité Hospital many years ago. Fortunately for the patients, lead colic is, generally speaking, not a fatal disease."

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Choreic Movements in an old Case of Hemiplegia.—As much interest attaches to "choreic" movements sometimes observed in the paralyzed limbs of a hemiplegic patient, a description of these movements exhibited in the following case admitted into the Birmingham General Hospital, under the care of Dr. Russell (*British Med. Journal*, Dec. 4, 1875), will not be without interest. They occurred in a young man, aged about 25, who had been partially paralyzed in his right side from his second year of age. He ascribed the paralysis to a fright, but could give no further particulars respecting it. The movements in question affected those muscles of the right side which are the seat of the paralysis in hemiplegia. They consisted of rapid energetic clonic contraction of all the muscles more or less simultaneously.

On some occasions, with considerable muscular action, the movements of the affected limb were of the most limited description; the antagonist muscles all contracting at once counteracted the effect produced by one another. Dr. Russell placed his hand on the limb, and felt all its muscles in active intermittent contraction, the contraction travelling down the limb from the shoulder, and yet the position of the scapula was little affected; the arm remained by the side, only the shoulder being slightly rotated inwards or outwards, in consequence of slight overaction of one or other of the scapular muscles. The fingers were more active, being chiefly extended and spread out, the former posture resulting from the flexors of the fingers losing their purchase, owing to the permanently bent position of the wrist. Of course, a marked exception was presented by the mouth, which was under no opposing influence from the opposite muscles; the muscles acting upon the right angle of the lips drew the angle forcibly outwards, and these muscles were aided by the violent action of the platysma on the same side, so that great distortion of the lower part of the face was the consequence. But at other times, especially when the movements were most violent, the exact opposition of antagonists was not maintained, and considerable movement resulted, though apparently wanting much of the complexity and range observed in chorea.

These movements differed from those of chorea in another and more characteristic particular; though the patient could not restrain the muscular action which has been described, he yet retained the power of employing the various groups of muscles in any manner he pleased. He could walk well, without deviating from a direct course, though occasionally, if he had a violent "snatch," he ran against persons in the street; he could grasp my hand or any other object without any trouble; but, owing to the permanent predominance of the flexors, he was quite unable to release his hold until aided artificially; yet the fingers simply closed on the object, and manifested none of the fidgetiness and intermitting grasp characteristic of chorea. Of course, he was quite incapable of performing the more delicate movements of the hand. The muscles affected were notably those of the right angle of the mouth, the right platysma, to a remarkable degree; the scapular muscles and those operating upon the shoulder; and the muscles of the upper and lower extremities. The muscles of the upper suffered much more than those of the lower extremity. The bilaterally acting muscles were spared almost, if not completely; those of the upper part of the face entirely, and also the muscles of the tongue. The chin could be raised during a violent paroxysm, and the sterno-mastoids were

quiet. The abdominal and lumbar muscles sometimes were slightly in action; but it seemed rather for the purpose of steadying the body. The wrist and the knee were maintained permanently in a semiflexed position, owing to the predominating action of the flexor muscles; but they could be extended artificially with facility. The movements occurred in paroxysms; but one often saw the patient almost still. They were quiet during sleep, but were remarkably under the influence of excitement. A dream would bring them on, and rouse the patient from sleep, or any mental excitement by day. During the day he was quiet whilst he was reading, or whilst his mind was fully engaged; but sometimes a paroxysm of movement would last all the day.

The limbs were of the same length with those of the opposite side. The girth of the right wrist equalled that of the left; but the girth around the heads of the metacarpal bones on the right was half an inch below that on the left side. The fingers were rather slender. The muscles of the right arm were smaller than those of the left, occasioning a lessened girth of one inch in the upper arm and of half an inch in the forearm. Sensation was normal. The fundus oculi was healthy, excepting for a posterior staphyloma. The sounds of the heart were natural.

The man was well developed, fully intelligent, and had good health. The movements, it should be added, had been present so long as he could remember, but not with so much severity as for the last few years.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Carbolic Acid as used for the purposes of Disinfection.—The following resolutions were adopted at a meeting of physicians recently held in New Orleans:—

1st. Carbolic acid, as used for purposes of "disinfection," by the Board of Health in New Orleans during the years 1867, 1870, 1871, 1872, 1873, 1874, and 1875, has failed to arrest smallpox, scarlet fever, and yellow fever.

2d. Carbolic acid, as used for purposes of "disinfection," by the Board of Health in New Orleans, has in several instances proved injurious to the inhabitants of the "*disinfected*" districts.

3d. The facts observed in New Orleans, during the practice of carbolic acid "disinfection" upon a larger scale than ever before in the history of sanitary science, sustain the view held by high authorities, that it is impossible to disinfect the atmosphere of an entire city, or even of a circumscribed area, as of two or more squares.

Cases of yellow fever have occurred in succession, at long intervals, in houses and localities which have been most thoroughly subjected to the so-called "carbolic acid disinfection." Instances have been observed where unacclimated individuals, returning from the country before cold weather had put an end to the disease, and entering those districts of the city in which carbolic acid had been most lavishly employed as a "disinfectant," have been attacked by yellow fever.

4th. Yellow fever has followed its usual course, increasing up to a certain period, and then declining with the fall of temperature and ceasing with the appearance of frost. No connection has been traced between the decline and cessation of the disease and the amount of carbolic acid used for purposes of "disinfection."—*New Orleans Med. and Surg. Journ.*, Nov. 1875.

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Prolonged Gestation. — Dr. FRANK WELLS records (*Boston Med. and Surg. Journ.*, Dec. 2, 1875) a case of this in which delivery took place 304 days from the date of sexual congress. The birth, which was a tedious one, necessitating the application of the forceps, was chiefly characterized by the almost entire absence of liquor amnii, only sufficient being discharged to make upon the sheet a stain of the size of a silver dollar. The child, which weighed eight and one-half pounds, looked as though it had been in a measure macerated in the amniotic fluid, its skin being loose and wrinkled, and the epidermis peeling off in strips. At this date (November, 1875), the child

(a boy) is healthy and vigorous, and weighs eighteen and one-half pounds.

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Delegates to the International Medical Congress, Philadelphia, 1876.—The Virginia State Medical Society has appointed the following delegates: L. S. Joynes, G. W. Semple, T. S. Michaels, J. S. D. Cullen, J. L. Dorsett, R. S. Payne, J. G. Cabell, J. S. Davis, L. B. Edwards, M. P. Christian. Alternates: Benj. Blackford, J. F. Harrison, O. B. Jenks, Geo. Ross, J. A. Johnson, W. S. Morris, Allan Payne, J. St. P. Gibson, John G. Skelton, Geo. W. West.—*Va. Med. Monthly*, Nov. 1875.

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The American Public Health Association.—This Association, the object of which is extremely disinterested and laudable, held its third annual meeting in Baltimore, on 9th of November and the four succeeding days. An unusually large number of papers on practical hygiene were read.

The following officers were elected: *President*, E. M. Snow, M.D., of Providence, R. I.; *First Vice-President*, John H. Rauch, M.D., of Chicago, Ills.; *Second Vice-President*, Prof. F. A. Walker, LL.D., of Yale College; *Treasurer*, Foster Jenkins, of Yonkers, N. Y. Executive Committee, Hon. A. W. Boardman, of Boston; J. S. Billings, M.D., U. S. A.; J. M. Woodworth, M.D., U. S. A.; Hon. L. H. Steiner, M.D., of Maryland; Ezra Hunt, M.D., New Jersey; and Jackson S. Schultz, Esq., New York.

Dr. Elisha Harris continues as Secretary.

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Virginia Medical Society.—At the annual meeting of this Society held at Richmond in October, the following officers were elected for the ensuing year. President, Dr. F. D. Cunningham, of Richmond; 1st Vice-President, Dr. Thomas B. Ward, Norfolk; 2d Vice-President, Dr. Benj. Blackford, Lynchburg; 3d Vice-President, Dr. Wm. F. Barr, Abingdon; 4th Vice-President, Dr. S. W. Carmichael, Fredericksburg; 5th Vice-President, Dr. R. W. Nelson, Charlottsville; 6th Vice-President, Dr. E. A. Drewry, Drewrysville; Recording Secretary, Dr. Landon B. Edwards, Richmond; Corresponding Secretary, Dr. Christopher Tompkins, Richmond; Treasurer, Dr. Landon B. Edwards, Richmond. —*Va. Med. Monthly*, Nov. 1875.

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The Indiana, Illinois, and Kentucky Tri-State Medical Association.—Dr. A. PATTON writes us that a convention of medical societies of the above-named States was held in Vincennes, Indiana, on the 26th and 27th of October last, at which a number of valuable papers were read, and it was resolved to form a society under the title given at the head of this notice.

The following officers were elected for the next year:—

President, Dr. J. W. Thompson, of Paducah, Ky. *Vice-Presidents*, Dr. J. B. Armstrong, Ind.; W. A. Smith, Ill.; J. H. Litcher. *Secretaries*, Drs. Burton and Beard of Ind. *Treasurer*, Dr. A. Patton, Ind.

A constitution was adopted and also the Code of Ethics of the American Medical Association.

The next meeting will be held at Vincennes on the last Tuesday in October, 1876.

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The Medical Profession of New York on Hospital Management.—In response to a call signed by the leading medical men of New York, a largely attended mass meeting of the profession of that city was held on the 30th of November, to elicit an expression of opinion regarding the relations which should exist between the boards of management of hospitals and their medical staff; the consideration of the subject having grown out of a difficulty which has for some time existed between the managers and the staff of the New York Presbyterian Hospital. After some remarks a committee was appointed to draft resolutions expressive of the sense of the meeting. It subsequently made the following report, which, as it relates to a principle in which the honour of the entire profession is involved, and deals with it so justly, we publish in full.

Whereas, certain facts have been laid before this meeting embodied in the following statements, viz., that,

At the Annual Meeting of the Board of Managers of the Presbyterian Hospital,

for the year 1875, four members of the medical staff were not reappointed, and were thus virtually dismissed; that no charges were preferred against those gentlemen; that no causes were alleged to have existed which assumed fault on their part, nor was a hearing afforded them, although very respectfully asked for; that this is the more remarkable when we take into account the facts that the measures against the medical gentlemen not reappointed were carried by a single vote; that respectful protests from the medical staff and from a very large number of medical men were made to the board of managers, but not regarded; that the vacancies thus made were filled without consultation with the medical staff; that several members of the medical staff subsequently resigned; that a committee of the board of managers was appointed to confer with the gentlemen who had resigned; that the board of managers contemptuously refused even to accept the report made by this committee, although it was of a conciliatory character, and thus gave additional evidence of the feeling that was entertained towards the medical profession.

That all the members of the committee except one, who was absent in Europe, instantly resigned. That other members of the board of managers, impressed by the injustice of these proceedings, also resigned.

In view of these facts, and of the principle that the good order and usefulness of hospitals must necessarily depend upon the maintenance of mutual respect and harmony between their boards of managers and their medical staffs, therefore be it resolved,

I. That the medical profession of New York cannot look with indifference upon these proceedings, but feel that such a precedent should not be established without protest on their part.

II. *Resolved*, That they believe that the four gentlemen dropped from the medical staff have not been treated with common justice.

III. *Resolved*, That no medical man should place himself in a position from which he may be dismissed without charges preferred or hearing allowed.

IV. *Resolved*, That we heartily approve of the action of those members of the medical staff who have resigned their positions, and thus refused to countenance an injustice done to fellow-members of their profession.

V. *Resolved*, That while we fully appreciate the great and wise beneficence of the founders and supporters of the Presbyterian Hospital in their efforts to secure a place of relief for the suffering poor, we deplore the treatment of the members of our profession, which has so much impaired the usefulness of what promised to be a great charity.

VI. *Resolved*, That in consideration of the primary importance of the relations of the medical profession to all hospitals, it is the sense of this meeting that similar occasions of disagreement between the boards of directors of hospitals and their medical staffs, as well as grave faults in the management or in the construction of hospitals, can be avoided only by an adequate representation of the medical profession in the membership of the boards of direction.

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The West Virginia Medical Student.—This is the title of a new monthly medical journal published at Wheeling, W. Va., of which Dr. JAMES E. REEVES is editor and proprietor. The editor is well known by his various contributions to medical literature, and his first number now on our table presents a very neat appearance. It contains four original articles, of which it will be observed that one only is by a resident of West Virginia. We welcome our new contemporary, and with pleasure place it on our exchange list.

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OBITUARY RECORD.—Died suddenly, Dec. 3d, of pulmonary apoplexy, aged 67, Dr. JAMES H. ARMSBY, Professor of Anatomy and Clinical Surgery in the Albany Medical College, N. Y. Dr. A. was a successful teacher, and his death will be especially deplored as a great loss by the College of which he was the founder and a successful teacher.

—— in Boston, Dec. 9th, CHARLES MIFFLIN, M.D. Dr. M. was born in Philadelphia, and was a descendant of a family

of Revolutionary fame, but for many years he has been a resident of Boston.

—— at Danville, Ky., Dec. 8th, of pulmonary phthisis, JOHN D. JACKSON, M.D. Dr. J. was one of the most eminent and learned physicians of Kentucky, and enjoyed in an unusual degree the confidence and respect of his contemporaries.

FOREIGN INTELLIGENCE.

Death from Chloroform.—A very few words seem to be necessary *à propos* of the painful calamity of the sudden death of Mrs. Childers, from the inhalation of chloroform self administered. They are the more necessary, that two deaths, equally sudden and sad, were recorded last week from the use of chloral—solidified chloroform—self-prescribed by its victims. Medical science, in bringing these divine narcoties to the relief of human suffering, has conferred a boon which, inestimable as it must be considered, is liable to great abuse. It should never be forgotten that of the three most potent anæsthetics now known, ether, nitrous oxide, and chloroform, the last is by far the most dangerous. It gives death suddenly, mysteriously, and often when least expected on *à priori* grounds. The medical practitioner who administers chloroform, either by inhalation or in the solid form as chloral, incurs a great responsibility, of which he is conscious and of which he is able to measure the extent; the unskilled person who indulges in these narcotics for the relief of pain, or as a nervous sedative, on his own responsibility, takes an unmeasurable risk, of which the fatal consequences are but too often shown publicly by sudden death; while the more subtle mischiefs which they produce, though less liable to occasion startling public catastrophes, are not the less widely observed by medical practitioners. The unauthorized use by unskilled persons of dangerous anæsthetics is a practice fraught with the utmost peril.—*Brit. Med. Journal*, Dec. 4, 1875.

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Ether and Chloroform.—Ether is preferred to chloroform as an anæsthetic in the Laboratory of Florence, because a very extensive experience has convinced Dr. SCHIFF that etherization carried to the last grade of insensibility never becomes dangerous to life as long as the movements of respiration are maintained. But even if the inhalation of ether be still further continued until the respiratory movements cease, or, in other words, the appearance of death is complete, death does not actually follow if only, at the moment when the thoracic walls are paralyzed, the inhalation is interrupted in order to begin suddenly a kind of artificial respiration by interrupted compression of the thoracic walls themselves. By this measure, the air impregnated with ether passes out of the lungs at every compression, and atmospheric air enters every time that the compression is relaxed, and the air so entering takes up more ether, which is again expelled at the subsequent compression. Thus the quantity of ether in the blood is diminished to such a degree as to be no longer sufficient to embarrass the action of the nervous centre of respiration, and thus breathing begins anew. Chloroform has been often popularly preferred to ether because it acts more rapidly, and its application is more agreeable to the patient who dislikes the smell of ether. But according to Dr. Schiff (whose views in this respect seem to be gaining ground in the present day), chloroform has a much more extensively paralyzing action than ether, and has, moreover—at least in man and other mammiferous animals,—a special influence on the nerves of the heart. Thus it happens, that, when chloroform is carried to such a degree as to weaken considerably the respiratory movements, it is sometimes impossible to restore them, in consequence of the weakness of the heart's action. Dr. Schiff goes so far as to state emphatically that a medical man is responsible for every case of death caused by the use of ether—by which he means that a careful watching of the respiration during the employment of this agent may always prevent death; while the effects of chloroform depend partly on individual predisposition, which medical science cannot always detect.—*Med. Times and Gaz.*, Dec. 4, 1875.

The Inoculability of Tuberculosis.—The adversaries of the doctrine of the inoculation of tuberculosis increase and multiply. At the recent International Medical Congress at Brussels, Professor Crooq strongly attacked several points in M. Villemin's doctrine, and, at the meeting of the Academy of Medicine on November 16th, Dr. Metzgner continued the onslaught. Some months since, M. Metzgner read a memoir before the Academy, in which he set forth the result of his first experiments on the non-inoculability of tubercle. The second memoir, to which we now refer, is the affirmative and extended complement of the first. Dr. Metzgner has chiefly devoted his memoir to the demonstration of these two points. 1. The inoculation of tuberculous matter produces a change which differs entirely from tubercle. 2. The inoculated animals which withstand these changes, and which are allowed to live for six months after, do not at the end of that time show any local or general lesion. Dr. Metzgner bases his demonstrations on one hundred and thirty experiments performed on rabbits. A committee of seven members of the Academy has been appointed to examine and report on M. Metzgner's memoirs, and to decide the important question of the inoculability and specificity of tuberculosis.—*British Med. Journ.*, Dec. 4, 1875.

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Tubercle of the Pancreas.—Dr. BARLOW exhibited to the Pathological Society of London (*Med. Times and Gazette*, Nov. 27, 1875) a specimen of tubercle of the pancreas which is said to be a very rare condition. A child of twenty-three months died a quarter of an hour after admission into the Great Ormond Street Hospital. It had suffered for months from "scrofula," and been acutely ill for a fortnight. General acute tuberculosis was found post-mortem, with caseous change in several glands, including the mesenteric. The exterior of the pancreas appeared to be normal, but white nodules were discovered in the head of the gland, six in number, similar to those familiar in the kidney. Microscopically a small-celled growth was discovered between and in the lobules; the gland-elements were granular in the neighbourhood.

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Diagnostic Value of the Bruit de Galop in Interstitial Nephritis.—M. POTAIN recently brought before the *Société Médicale des Hôpitaux* the importance of the *bruit de galop*, which is occasionally met with in the auscultation of the heart, as a means of diagnosis of interstitial nephritis. This bruit is presystolic, occupying a portion of the long pause, and having its maximum towards the apex. According to M. Potain, it is met with especially in the subjects of interstitial nephritis, and disappears at the same time as the renal disease. In discussing the mechanism of the bruit, M. Potain at once rejects the explanation based upon the non-simultaneous contraction of the two sides of the heart, and endeavours to prove that it is due to exaggerated distension of the hypertrophied auricle.—*Dublin Medical Journ.*, Nov. 1875, from *Gaz. Hebdom.*, Sept. 3.

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Feeding by Subcutaneous Injections.—A method of forcible alimentation, which possesses at least the merit of novelty, has recently been put in practice by Dr. J. KRUEG, who narrates his experience in the *Wiener Med. Wochenschrift*. It consists in the injection of aliments into the subcutaneous tissue by means of a hypodermic syringe. Dr. Krueg recalls the fact that it has been shown by MM. Menzel and Pereo that nutritious matter may be absorbed in this way; a quantity of fatty liquid, from one to eight drachms, having been taken up in forty hours, and that solutions of sugar, milk, and yelk of egg act in the same way. Peptones have also been shown to be thus absorbed by Stricker and Oser. Dr. Krueg tried the method in a case of insanity with refusal of food, in which the patient having been nourished for twenty-seven months by means of the stomach-pump, and the introduction of the tube becoming difficult from his violence, at one time it could only be introduced once in ten days. Dr. Krueg, therefore, injected about half an ounce and then one ounce of oil daily

beneath the skin, dividing this quantity between from two to five different points of injection, the operation being done gradually, and lasting about an hour. The injection was not painful, and the swelling disappeared by the next day. Beaten-up egg was not so successful, producing an abscess. For nine days at a time the patient was entirely dependent on this process for nourishment, which was subsequently repeated several times. We need scarcely say that this method of feeding is one not likely to be of much use; and, indeed, it seems to have been required in this case only because the old and barbarous method of feeding by the stomach-pump was employed, instead of the more simple and expeditious way of feeding by the nose. As a means of inducing unwilling patients to take food, the punctures required may have as much value as any other mode of torture; and, indeed, some temporary result of the kind seems to have been gained in the case narrated.—*Lancet*, Nov. 20, 1875.

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On the Rational Treatment of Common Tapeworm.—At a late meeting of the Medical Society of London, Dr. BRUNTON read a paper on this subject (*Lancet*, December 4, 1875). After stating the varieties met with in this country, and mentioning the anomalous symptoms to which they give rise (their very anomaly, he remarked, affording a clue to the diagnosis), he stated that the chief points to be observed in the treatment were; a preliminary starvation of twenty-four hours, and the administration of a combination of kameela and male fern—namely, two drachms of kameela to be rubbed up with a little gum and water till an emulsion is formed, and then two drachms of oil of male fern to be added, and the whole triturated in a mortar, with a gradual addition of water till a three-ounce mixture is formed, of which half is to be given at bedtime, and the remainder four hours later. This he had never known to fail. He insisted on the quality of the drugs being good, and spoke of the after-treatment by tonics.

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Quinetum.—A preparation of the whole alkaloids separated from East India red bark has been used for some time in the Indian hospitals, as well as in private practice, with great success. The concurrent testimony of medical men in our Indian possessions is to the effect that quinine is not so greatly superior to the whole alkaloids as to make it worth while to separate the sulphate in its pure state. Mr. Thomas Whiffen of the Quinine Works, Battersea, now offers to the profession a similar preparation, which he calls quinetum. It is in the form of a fine granular non-adherent powder of a pale buff colour. The proportions of the various alkaloids present will of necessity vary with the sample of bark used; but, we think, not so much as to be of moment therapeutically. Sulphate of quinetum is a white crystalline body with a faint pink tinge, greatly resembling sulphate of quinine; and we are informed that the preparation can be supplied to the profession at about one-half of the cost of quinine.—*Brit. Med. Journ.*, Nov. 27, 1875.

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Sugar in Healthy Urine.—Dr. PAVY demonstrated to the Royal Medical and Chirurgical Society (*Med. Times and Gaz.*, Dec. 4, 1875) the existence of sugar in healthy urine. This was, he believed, much more commonly to be found than was supposed. It might be obtained in various ways, especially by acetate of lead. Thus procured, sugar might, as he showed, be demonstrated in healthy urine by all the ordinary tests—Moore's or the liquor potassæ test, Böttger's or the bismuth test, Fehling's modification of the copper test, and, finally, the crucial fermentation test.

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OBITUARY RECORD.—Died suddenly, Nov. 26th, in the 67th year of his age, in the Library of the Academy of Medicine, JOACHEM-ALBIN CARDOZA GIRALDES. M G. was Member of the Academy of Medicine and of the Society of Surgery, an Agrégé of the Faculty of Medicine, Surgeon to the Children's Hospital, Officer of the Legion of Honour, etc etc. etc. He was master of several living languages, and possessed a vast amount of bibliographical knowledge.

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